

STATE OF ILLINOIS

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Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>300</u>	Skilled (SNF)	<u>300</u>	<u>109,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>300</u>	TOTALS	<u>300</u>	<u>109,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>42,808</u>	<u>2,222</u>	<u>10,098</u>	<u>55,128</u>	8
9	SNF/PED					9
10	ICF	<u>41,037</u>	<u>240</u>	<u>92</u>	<u>41,369</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>83,845</u>	<u>2,462</u>	<u>10,190</u>	<u>96,497</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.88%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/01/76

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 300 and days of care provided 6,835Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning: 01/01/04

Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	302,741	106,082	11,640	420,463		420,463	4,805	425,268			1
2	Food Purchase		363,503		363,503	(27,596)	335,907	(92)	335,814			2
3	Housekeeping	316,310	58,015	374	374,699		374,699	14,930	389,629			3
4	Laundry	84,175	15,903		100,078		100,078		100,078			4
5	Heat and Other Utilities			203,272	203,272		203,272	4,356	207,628			5
6	Maintenance	104,668	11,343	108,233	224,244		224,244	(10,798)	213,446			6
7	Other (specify):*											7
8	TOTAL General Services	807,894	554,846	323,519	1,686,259	(27,596)	1,658,663	13,201	1,671,863			8
	B. Health Care and Programs											
9	Medical Director			58,000	58,000		58,000		58,000			9
10	Nursing and Medical Records	4,025,786	335,644	42,272	4,403,702		4,403,702	(22,283)	4,381,419			10
10a	Therapy	147,944		92	148,036		148,036		148,036			10a
11	Activities	189,890	15,409	2,448	207,747		207,747		207,747			11
12	Social Services	143,096		3,992	147,088		147,088		147,088			12
13	Nurse Aide Training											13
14	Program Transportation			258	258		258		258			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,506,716	351,053	107,062	4,964,831		4,964,831	(22,283)	4,942,548			16
	C. General Administration											
17	Administrative	281,020		405,000	686,020		686,020	(361,252)	324,768			17
18	Directors Fees											18
19	Professional Services			626,826	626,826		626,826	(460,193)	166,633			19
20	Dues, Fees, Subscriptions & Promotions			230,700	230,700		230,700	(126,567)	104,133			20
21	Clerical & General Office Expenses	559,357	3,300	201,229	763,886		763,886	(68,640)	695,246			21
22	Employee Benefits & Payroll Taxes			1,163,729	1,163,729	27,596	1,191,325	(146,283)	1,045,042			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,130	7,130		7,130	749	7,879			24
25	Other Admin. Staff Transportation			951	951		951		951			25
26	Insurance-Prop.Liab.Malpractice			352,040	352,040		352,040	43,760	395,800			26
27	Other (specify):*							69,518	69,518			27
28	TOTAL General Administration	840,377	3,300	2,987,605	3,831,282	27,596	3,858,878	(1,048,908)	2,809,970			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,154,987	909,199	3,418,186	10,482,372		10,482,372	(1,057,990)	9,424,382			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

#0020842

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			251,787	251,787		251,787	148,380	400,167			30
31	Amortization of Pre-Op. & Org.							214	214			31
32	Interest			132,938	132,938		132,938	390,999	523,937			32
33	Real Estate Taxes							280,902	280,902			33
34	Rent-Facility & Grounds			960,887	960,887		960,887	(958,125)	2,762			34
35	Rent-Equipment & Vehicles			55,099	55,099		55,099	(37,760)	17,339			35
36	Other (specify):*			183	183		183	3,038	3,221			36
37	TOTAL Ownership			1,400,894	1,400,894		1,400,894	(172,352)	1,228,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	189,849	201,141	90,955	481,945		481,945		481,945			39
40	Barber and Beauty Shops			1,673	1,673		1,673		1,673			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):*	55,214			55,214		55,214		55,214			43
44	TOTAL Special Cost Centers	245,063	201,141	257,328	703,532		703,532		703,532			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,400,050	1,110,340	5,076,408	12,586,798		12,586,798	(1,230,342)	11,356,456			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(76,799)	30		9
10	Interest and Other Investment Income	(18,073)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,289)	21		18
19	Entertainment				19
20	Contributions	(17,967)	20		20
21	Owner or Key-Man Insurance	(146,283)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,386)	21		24
25	Fund Raising, Advertising and Promotional	(102,731)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,967)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,513)	20		28
29	Other-Attach Schedule	(464,992)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (878,092)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(352,250)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (352,250)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,230,342)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Hakhtel Terrace Nsg Ctr, Inc.

ID#: 0020842

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Nonallowable Interest	\$ (46,759)	32 1
2	Finance Charge	04	32 2
3	Non-Allowable Auto Lease	(41,273)	35 3
4	Collection Fees	(24,960)	21 4
5	Non-Allowable Professional Fee	(4,800)	19 5
6	Marketing Seminar	(200)	24 6
7	Wage Assignment Fees	(160)	10 7
8	Venue Expenses	(22,175)	10 8
9	Bank Service Charges	(29,295)	21 9
10	Franchise Tax	(517)	21 10
11	Theft and Damage Loss	(896)	24 11
12	COPI-Data	(5,614)	20 12
13	Non-Allowable Management Fee	(45,000)	17 13
14	Trait Fees - Bldg Co	(500)	21 14
15	Cultivated R&M	(16,141)	86 15
16	Non-Allowable Expense	(231,236)	25 16
17	Non-Allowable Legal	(1,312)	19 17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
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87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(464,992)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary						4,805						4,805	1
2	Food Purchase	(92)											(92)	2
3	Housekeeping						14,930						14,930	3
4	Laundry													4
5	Heat and Other Utilities						4,356						4,356	5
6	Maintenance	(16,141)					5,343						(10,798)	6
7	Other (specify):*													7
8	TOTAL General Services	(16,233)					29,434						13,201	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(22,283)											(22,283)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(22,283)											(22,283)	16
	C. General Administration													
17	Administrative	(45,000)		(133,611)	(183,333)	692							(361,252)	17
18	Directors Fees													18
19	Professional Services	(6,112)	11,780	73	1,513	404	(467,851)						(460,193)	19
20	Fees, Subscriptions & Promotions	(127,822)				179	1,076						(126,567)	20
21	Clerical & General Office Expenses	(337,150)	500	210		2,055	265,745						(68,640)	21
22	Employee Benefits & Payroll Taxes	(146,283)											(146,283)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(300)					1,049						749	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		42,684				1,076						43,760	26
27	Other (specify):*			158	3,285	4,469	61,606						69,518	27
28	TOTAL General Administration	(662,667)	54,964	(133,170)	(178,535)	7,799	(137,299)						(1,048,908)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(701,183)	54,964	(133,170)	(178,535)	7,799	(107,865)						(1,057,990)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(76,799)	207,762				17,417						148,380	30
31	Amortization of Pre-Op. & Org.						214						214	31
32	Interest	(58,837)	428,134				21,702						390,999	32
33	Real Estate Taxes		270,428				10,474						280,902	33
34	Rent-Facility & Grounds		(958,125)										(958,125)	34
35	Rent-Equipment & Vehicles	(41,273)					3,513						(37,760)	35
36	Other (specify):*		3,038										3,038	36
37	TOTAL Ownership	(176,909)	(48,763)				53,320						(172,352)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(878,092)	6,201	(133,170)	(178,535)	7,799	(54,545)						(1,230,342)	45

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842

Report Period Beginning:

01/01/04Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 958,125	Halsted Terrace Associates	100.00%	\$	(958,125)	1
2	V	32 Interest Income/Expense	14,562	Halsted Terrace Associates	100.00%	442,696	428,134	2
3	V	26 Insurance - General		Halsted Terrace Associates	100.00%	42,684	42,684	3
4	V	19 Accounting		Halsted Terrace Associates	100.00%	11,780	11,780	4
5	V	21 Trust Fees		Halsted Terrace Associates	100.00%	500	500	5
6	V	33 Real Estate Taxes		Halsted Terrace Associates	100.00%	270,428	270,428	6
7	V	30 Depreciation		Halsted Terrace Associates	100.00%	207,762	207,762	7
8	V	36 Amortization of Loan Costs		Halsted Terrace Associates	100.00%	3,038	3,038	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 972,687			\$ 978,888	\$ * 6,201	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 1,389	\$ 1,389
16	V	19 PROFESSIONAL FEES				73	73
17	V	21 OFFICE				210	210
18	V	27 PAYROLL TAXES				158	158
19	V						
20	V						
21	V	17 MARVIN NEEDLE-CONS. FEES					
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V	17 MANAGEMENT FEES	135,000				(135,000)
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 135,000			\$ 1,830	\$ * (133,170)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr, Inc.

0020842

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 BERNIE HOLLANDER-SAL.	\$	SHAYMARK MANAGEMENT CORP.	100.00%	\$ 41,667	\$ 41,667	15
16	V	19 PROFESSIONAL FEES				1,513	1,513	16
17	V	27 PAYROLL TAXES				3,285	3,285	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V	17 MANAGEMENT FEES	225,000				(225,000)	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 225,000			\$ 46,465	\$ * (178,535)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 21,053	\$ 21,053
16	V	19 PROFESSIONAL FEES				404	404
17	V	20 FEES, SUBSCRIPTIONS				179	179
18	V	21 CLERICAL AND GENERAL				2,055	2,055
19	V	27 GEN ADMIN.- EMP. BEN.				4,469	4,469
20	V						
21	V						
22	V						
23	V						
24	V	17 MANAGEMENT FEES	20,361				(20,361)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 20,361			\$ 28,160	\$ * 7,799

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY	\$	ITEX COMPANY	100.00%	\$ 4,805	\$ 4,805 15
16	V	3 HOUSEKEEPING				14,930	14,930 16
17	V	5 UTILITIES				4,356	4,356 17
18	V	6 REPAIRS AND MAINT.				5,343	5,343 18
19	V	19 PROFESSIONAL FEES	268			10,257	9,989 19
20	V	20 FEES, SUBSCRIPTIONS				1,076	1,076 20
21	V	21 CLERICAL AND GENERAL				29,318	29,318 21
22	V	24 EDUCATION/SEMINARS				1,049	1,049 22
23	V	26 INSURANCE				1,076	1,076 23
24	V	27 EMPLOYEE BENEFITS				463	463 24
25	V	30 DEPRECIATION				17,417	17,417 25
26	V	31 AMORTIZATION				214	214 26
27	V	32 INTEREST				21,702	21,702 27
28	V	33 REAL ESTATE TAXES				10,474	10,474 28
29	V	35 EQUIPMENT RENTAL				3,513	3,513 29
30	V						
31	V						
32	V	21 CLERICAL SALARIES				236,427	236,427 32
33	V	27 GEN ADMIN. - EMP. BEN.				61,143	61,143 33
34	V						
35	V	19 BOOKKEEPING SERVICES	477,840				(477,840) 35
36	V						
37	V						
38	V						
39	Total		\$ 478,108			\$ 423,563	\$ * (54,545) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc. # 0020842 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	President	Management	83.33%	See Attached	20.00	30.77%	Sal, Alloc Sal	\$ 111,667	17-1, 17-7	1
2	Jack Rajchenbach	Vice President	Management	10.00%	See Attached	1.00	1.54%	Alloc Sal	1,389	17-7	2
3	Mark Hollander	Relative	Executive	0%	See Attached	20.00	33.33%	Salary	25,000	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 138,056		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc. # 0020842 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization JLR MANAGEMENT CORP.Street Address 6633 NORTH LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 76,400	\$ 76,400	1	\$ 1,389	1
2	19 PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	4,020		1	73	2
3	21 OFFICE	AVG. HOURS WORKED	55	10	11,524	9,614	1	210	3
4	27 PAYROLL TAXES	AVG. HOURS WORKED	55	10	8,689		1	158	4
5									5
6									6
7	17 MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 136,929	\$ 86,014		\$ 1,830	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization SHAYMARK MANAGEMENT CORP.Street Address 6633 NORTH LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	48	5	\$ 100,000	\$ 100,000	20	\$ 41,667	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	5	3,632	20	1,513		2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	48	5	7,883	20	3,285		3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 111,515	\$ 100,000		\$ 46,465	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CAREPATH HEALTH NETWORKStreet Address 6633 N LINCOLN AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (888) 707-6700Fax Number (847) 679-2150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMINISTRATIVE	CARE PATH FEES	227,090	9	\$ 234,811	\$ 234,811	20,361	\$ 21,053	1
2	19 PROFESSIONAL FEES	CARE PATH FEES	227,090	9	4,511		20,361	404	2
3	20 FEES, SUBSCRIPTIONS	CARE PATH FEES	227,090	9	2,000		20,361	179	3
4	21 CLERICAL AND GENERAL	CARE PATH FEES	227,090	9	22,918		20,361	2,055	4
5	27 GEN ADMIN.- EMP. BEN.	CARE PATH FEES	227,090	9	49,841		20,361	4,469	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 314,081	\$ 234,811		\$ 28,160	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ITEX COMPANYStreet Address 6633 N. LINCOLN AVE.City / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	465,918	5	\$ 20,387	\$ 109,800	\$ 4,805	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	465,918	5	63,352	109,800	14,930	2
3	5	UTILITIES	AVAILABLE BED DAYS	465,918	5	18,482	109,800	4,356	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	465,918	5	22,673	109,800	5,343	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	465,918	5	43,523	109,800	10,257	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	465,918	5	4,565	109,800	1,076	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	465,918	5	124,405	109,800	29,318	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	465,918	5	4,449	109,800	1,049	8
9	26	INSURANCE	AVAILABLE BED DAYS	465,918	5	4,565	109,800	1,076	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	465,918	5	1,965	109,800	463	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	465,918	5	73,905	109,800	17,417	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	465,918	5	908	109,800	214	12
13	32	INTEREST	AVAILABLE BED DAYS	465,918	5	92,090	109,800	21,702	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	465,918	5	44,443	109,800	10,474	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	465,918	5	14,907	109,800	3,513	15
16									16
17									17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		6	784,794	784,794	236,427	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		6	202,958		61,143	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,522,371	\$ 784,794	\$ 423,563	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc. # 0020842 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc. # 0020842 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc. # 0020842 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.# 0020842

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc. # 0020842 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Cambridge		X	Mortgage	\$43,906.00	07/01/03	\$ 8,276,700	\$ 8,159,290	07/01/38	5.4000	\$ 442,696	1	
2	Chase Auto Financing		X	Auto Loan	\$1,343.00	09/21/01	43,346		08/21/04	7.5000	132	2	
3	ABB Business Finance		X	Paging System	\$541.00	07/01/01	25,393	9,000	06/01/06	10.1300	1,206	3	
4	Hill Rom/TCF Leasing		X	Video Equipment				8,873			548	4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Bank One		X	Working Capital				2,220,000			82,439	6	
7	A.I. Credit		X	Insurance Financing							7,849	7	
8	See Supplemental Schedule							206,237			(10,933)	8	
9	TOTAL Facility Related				\$45,790.00		\$ 8,345,439	\$ 10,603,400			\$ 523,937	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 8,345,439	\$ 10,603,400			\$ 523,937	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Interest Income		X				\$	\$			\$	(18,073)	8						
9	Interest Income - Bldg Co		X									(14,562)	9						
10	Shareholder Loans	X						206,237				40,759	10						
11	Nonallowable Interest											(40,759)	11						
12	Allocate ITEX		X									21,702	12						
13													13						
14	TOTAL Working Capital							206,237				(10,933)	14						
	B. Non-Facility Related*																		
15							\$	\$			\$		15						
16													16						
17													17						
18													18						
19													19						
20	TOTAL Non-Facility Related												20						

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Halsted Terrace Nsg Ctr. Inc.**# **0020842** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	279,522		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	278,742		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(780)		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	281,682		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	280,902		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	283,668	8		
	2000	256,659	9		
	2001	263,375	10		
	2002	266,212	11		
	2003	268,268	12		
Accrual - 2003 Taxes \$268,268 X 1.05 = \$281,682					
Allocated from ITEX/A.K. Care \$10,474					
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Halsted Terrace Nsg Ctr. Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020842

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>25-16-316-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>26,706.23</u>	\$ <u>26,706.23</u>
2. <u>25-16-316-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>25,644.96</u>	\$ <u>25,644.96</u>
3. <u>25-16-316-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>87,476.02</u>	\$ <u>87,476.02</u>
4. <u>25-16-316-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>128,440.93</u>	\$ <u>128,440.93</u>
5. <u>10-35-312-022-0000</u>	<u>Home Office</u>	\$ <u>46,549.68</u>	\$ <u>10,487.39</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>314,817.82</u></u>	\$ <u><u>278,755.53</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Halsted Terrace Nsg Ctr. Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020842

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.
Square Feet:
60,068

B. General Construction Type:

Exterior
Brick

Frame

Number of Stories
3

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☒ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
214

4. Dates Incurred:

Nature of Costs:
Allocate ITEX

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 855,000	1
2					2
3	TOTALS			\$ 855,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning:

01/01/04

Ending:

12/31/04

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various	1978	750			20	-		750
10	Various	1979	12,807			20	74	74	12,749
11	Various	1980	35,915			20	-		35,915
12	Various	1981	13,910			20	-		13,910
13	Various	1982	8,814			20	-		8,814
14	Various	1983	12,936			20	-		12,936
15	Various	1984	20,560			20	-		20,560
16	Various	1985	18,883			20	45	45	18,874
17	Various	1986	2,456			20	103	103	2,342
18	Various	1987	4,000			20	127	127	2,210
19	Various	1988	82,596			20	2,621	2,621	42,519
20	Various	1989	1,225			20	39	39	600
21	Various	1990	91,597			20	3,783	3,783	48,811
22	Various	1993	53,620			20	2,681	2,681	33,880
23	Various	1995	137,959			20	7,064	7,064	66,138
24	Various	1996	538,107			20	26,907	26,907	243,892
25	Various	1997	76,548			20	3,910	3,910	29,628
26	Various	1998	77,488			20	3,875	3,875	25,240
27	Various	1999	278,572			20	13,997	13,997	80,993
28	Various	2000	48,393			20	2,248	2,248	10,540
29							-		-
30							-		-
31							-		-
32							-		-
33							-		-
34							-		-
35							-		-
36							-		-

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		8,125,379	207,194		40,036	(167,158)		67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		463,891	11,152		15,093	3,941	171,193	68
69	Financial Statement Depreciation			251,787			(251,787)		69
70	TOTAL (lines 4 thru 69)		\$ 10,106,406	\$ 470,133		\$ 122,603	\$ (347,530)	\$ 882,494	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,106,406	\$ 470,133		\$ 122,603	\$ (347,530)	\$ 882,494	1
2	Voicemail Install	2001	1,229		20	123	123	400	2
3	Electrical Work	2001	696		20	35	35	113	3
4	Boilers	2001	56,500		20	2,825	2,825	8,946	4
5	Paging System	2001	25,443		20	1,272	1,272	4,452	5
6	Wallcoverings	2001	754		20	38	38	145	6
7	Light Fixtures	2001	522		20	26	26	89	7
8	Elevator Flooring	2001	597		20	30	30	118	8
9	Elevator Flooring	2001	784		20	39	39	154	9
10	Painting	2001	3,779		20	189	189	662	10
11	Booster Power Supply	2001	876		20	44	44	142	11
12	Ac Repair	2001	2,397		20	120	120	440	12
13	Sprinkler Repair	2001	1,014		20	51	51	186	13
14	Handrail	2001	600		20	30	30	105	14
15	Hot Water Valve Repa	2001	850		20	43	43	146	15
16	Hot Water Valve Repa	2001	1,419		20	71	71	231	16
17	Carpeting	2002	4,550		20	650	650	1,517	17
18	Border Patient'S Room	2002	1,173		20			1,173	18
19	Paint	2002	713		20	71	71	196	19
20	Sink	2002	642		20	64	64	150	20
21	Paint	2002	532		20	53	53	120	21
22	Copper Drain	2002	1,400		20	140	140	420	22
23	Roof Repair	2002	974		20	97	97	260	23
24	Cable Connectors/Outlets (Electric)	2002	1,100		20	110	110	266	24
25	Cable Connectors/Outlets (Electric)	2002	990		20	99	99	231	25
26	Fixtures	2002	705		20	71	71	147	26
27	Expansion Coupler	2002	1,405		20	141	141	422	27
28	Electrical & Fixtures	2002	590		20	59	59	177	28
29	Cable & Lines	2002	528		20	53	53	145	29
30	Chiller	2002	2,932		20	293	293	757	30
31	Chiller	2002	1,697		20	170	170	424	31
32	Flow Switches	2002	1,185		20	119	119	286	32
33	Carrier Unit	2002	759		20	76	76	177	33
34	TOTAL (lines 1 thru 33)		\$ 10,225,741	\$ 470,133		\$ 129,805	\$ (340,328)	\$ 905,691	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,225,741	\$ 470,133		\$ 129,805	\$ (340,328)	\$ 905,691	1
2	Electrical Lines	2002	585		20	59	59	137	2
3	Air Conditioner Repair	2002	1,731		20	173	173	389	3
4	Boiler & Pump	2002	1,089		20	109	109	236	4
5	Wallcoverings	2003	5,601		20			5,601	5
6	Window Treatments	2003	451		20	23	23	45	6
7	Flooring	2003	14,743		20	1,474	1,474	2,949	7
8	Flooring	2003	2,488		20	249	249	498	8
9	Flooring	2003	14,743		20	1,474	1,474	2,949	9
10	Flooring	2003	2,488		20	249	249	498	10
11	Light Fixtures	2003	3,685		20	184	184	353	11
12	Window Treatments	2003	5,305		20	265	265	508	12
13	Carpeting	2003	3,146		20	157	157	301	13
14	Flooring	2003	21,810		20	2,181	2,181	4,180	14
15	Flooring	2003	4,550		20	455	455	872	15
16	Drapery And Rods	2003	5,882		20	294	294	539	16
17	Cleanout Covers	2003	1,700		20	170	170	298	17
18	Carpeting	2003	15,447		20	772	772	1,287	18
19	Insulation	2003	1,208		20	121	121	201	19
20	Insulation	2003	7,422		20	742	742	1,237	20
21	Roof Compressor	2003	14,394		20	720	720	1,140	21
22	Water Pump	2003	1,626		20	81	81	129	22
23	Compressor	2003	2,637		20	132	132	198	23
24	Carpeting	2003	2,663		20	133	133	200	24
25	Wallcovering	2003	21,003		20	1,050	1,050	1,488	25
26	Roof Repairs	2003	6,044		20	604	604	907	26
27	Flooring	2003	7,564		20	756	756	1,072	27
28	Flooring	2003	5,600		20	373	373	529	28
29	Flooring	2003	66,858		20	4,457	4,457	6,314	29
30	Light Fixtures	2003	780		20	39	39	55	30
31	Computer Cabeling	2003	1,669		20	334	334	473	31
32	Flooring	2003	6,113		20	611	611	764	32
33	Water Heater Repairs	2003	2,004		20	100	100	125	33
34	TOTAL (lines 1 thru 33)		\$ 10,478,770	\$ 470,133		\$ 148,346	\$ (321,787)	\$ 942,163	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,478,770	\$ 470,133		\$ 148,346	\$ (321,787)	\$ 942,163	1
2	Light Fixtures	2003	1,300		20	65	65	81	2
3	Flooring	2003	553		20	55	55	69	3
4	Flooring	2003	8,559		20	856	856	1,070	4
5	Flooring	2003	24,530		20	2,453	2,453	3,066	5
6	Light Fixtures	2003	520		20	26	26	30	6
7	Flooring	2003	7,564		20	756	756	819	7
8	Flooring	2003	5,600		20	560	560	607	8
9	Flooring	2003	66,858		20	6,686	6,686	7,243	9
10	Flooring	2003	8,559		20	856	856	927	10
11	Flooring	2003	553		20	55	55	60	11
12	Flooring	2003	6,113		20	611	611	662	12
13	Flooring	2003	7,780		20	778	778	843	13
14	Flooring	2003	41,155		20	4,116	4,116	4,458	14
15	Room Renovation	2003	10,670		20	1,067	1,067	1,156	15
16	Light Fixtures	2003	2,795		20	140	140	151	16
17	Dialysis Room Plumbing	2003	12,984		20	1,298	1,298	1,407	17
18	Hood Duct	2003	595		20	60	60	114	18
19	Nurse Call Unit	2003	515		20	103	103	197	19
20	Sprinkler System Drain	2003	516		20	52	52	90	20
21	Valves	2003	1,211		20	121	121	192	21
22	Gas Saftey Valve	2003	542		20	54	54	81	22
23	Connector & Insulation	2003	500		20	50	50	79	23
24	Plate Assembly	2003	741		20	74	74	105	24
25	Air Conditioner Motor	2003	1,351		20	68	68	79	25
26	Wiring	2004	1,194		20	119	119	119	26
27	Electric Installation	2004	6,090		20	609	609	609	27
28	Cables And Wiring	2004	2,100		20	88	88	88	28
29	Air Conditioning	2004	3,806		20	95	95	95	29
30	Air Conditioners	2004	4,046		20	472	472	472	30
31	Pipes And Electrical	2004	4,950		20	330	330	330	31
32	Room Fixtures And Outlets	2004	1,165		20	233	233	233	32
33	Flooring	2004	9,400		20	1,880	1,880	1,880	33
34	TOTAL (lines 1 thru 33)		\$ 10,723,585	\$ 470,133		\$ 173,132	\$ (297,001)	\$ 969,575	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

12/31/04

****Improvement type must be detailed in order for the cost report to be considered complete.**

12/31/04

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1 Totals from Page 12F, Carried Forward		\$ 10,752,980	\$ 470,133		\$ 176,712	\$ (293,421)	\$ 973,155		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34 TOTAL (lines 1 thru 33)		\$ 10,752,980	\$ 470,133		\$ 176,712	\$ (293,421)	\$ 973,155		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

12/31/04

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 10,752,980	\$ 470,133		\$ 176,712	\$ (293,421)	\$ 973,155	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,752,980	\$ 470,133		\$ 176,712	\$ (293,421)	\$ 973,155	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,752,980	\$ 470,133		\$ 176,712	\$ (293,421)	\$ 973,155	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,752,980	\$ 470,133		\$ 176,712	\$ (293,421)	\$ 973,155	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

12/31/04

****Improvement type must be detailed in order for the cost report to be considered complete.**

STATE OF ILLINOIS

Page 12-BLDG

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	300		1994		\$ 7,334,294	\$ 187,711		\$	\$(187,711)	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Halsted Associates			1994	791,085	19,483		40,036	20,553		9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,125,379	\$ 207,194		\$ 40,036	\$ (167,158)	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12-REP

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

0020842

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	Allocation from ITEX/A.K. Care	1993		\$ 378,017	\$ 9,693	35	\$ 10,800	\$ 1,107	\$ 125,105
5									
6									
7									
8									
Improvement Type**									
9	Allocation from ITEX/A.K. Care	1993		47,565	574	20	2,378	1,804	27,841
10	Allocation from ITEX/A.K. Care	1994		25,548	665	20	1,277	612	13,134
11	Allocation from ITEX/A.K. Care	1995		4,354	11	20	218	207	2,002
12	Allocation from ITEX/A.K. Care	1996		246	-	20	12	(12)	112
13	Allocation from ITEX/A.K. Care	1997		7,345	188	20	367	179	2,754
14	Allocation from ITEX/A.K. Care	1999		816	21	20	41	20	245
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
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32									
33									
34									
35									
36									

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 463,891	\$ 11,152		\$ 15,093	\$ 3,917	\$ 171,193	70

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,828,625	\$ 3,359	\$ 199,727	\$ 196,368	10	\$ 1,390,708	71
72	Current Year Purchases	144,794	3,473	21,227	17,754	10	21,227	72
73	Fully Depreciated Assets	715,467				10	715,467	73
74								74
75	TOTALS	\$ 2,688,886	\$ 6,832	\$ 220,954	\$ 214,122		\$ 2,127,402	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2001 VEHICLE	2001	\$ 25,000	\$	\$ 2,500	\$ 2,500	5	\$ 8,333	76
77										77
78										78
79										79
80	TOTALS			\$ 25,000	\$	\$ 2,500	\$ 2,500		\$ 8,333	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,321,866	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 476,965	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 400,166	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (76,799)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,108,890	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2001 VEHICLE - 2001	\$ 41,173	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 41,173	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Storage				2,762			6
7	TOTAL				\$ 2,762			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 17,340

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 68,439		\$ 9,529	\$		\$ 77,968	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	117,354					117,354	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				135,354		135,354	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			4,056		81,426	65,787		151,269	13
14	TOTAL			\$ 189,849		\$ 90,955	\$ 201,141		\$ 481,945	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,000	\$ 382,913	1
2	Cash-Patient Deposits	131,675	131,675	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,118,577	1,118,577	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	273,524	293,913	6
7	Other Prepaid Expenses	24,282	24,282	7
8	Accounts Receivable (owners or related parties)	771,825	771,825	8
9	Other(specify): See Attached Schedule	301,315	318,819	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,622,198	\$ 3,042,004	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		855,000	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cost	1,690,495	1,734,865	15
16	Equipment, at Historical Cost	2,123,175	3,019,343	16
17	Accumulated Depreciation (book methods)	(2,664,058)	(5,816,155)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,830	108,160	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(183)	(4,740)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	568,688	876,145	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,719,947	\$ 8,771,516	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,342,145	\$ 11,813,520	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,775,019	\$ 1,775,019	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	141,000	141,000	28
29	Short-Term Notes Payable	2,436,103	2,436,103	29
30	Accrued Salaries Payable	414,773	414,773	30
31	Accrued Taxes Payable (excluding real estate taxes)	49,280	49,280	31
32	Accrued Real Estate Taxes(Sch.IX-B)		281,682	32
33	Accrued Interest Payable	440	37,157	33
34	Deferred Compensation	30,000	30,000	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule		9,588	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,846,615	\$ 5,174,602	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,007	8,167,297	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 8,007	\$ 8,167,297	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,854,622	\$ 13,341,899	46
47	TOTAL EQUITY (page 18, line 24)	\$ (512,477)	\$ (1,528,379)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,342,145	\$ 11,813,520	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 144,044	1
2	Restatements (describe):		2
3	See Attached	(708,309)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (564,265)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	51,788	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 51,788	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (512,477)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,941,131	1
2	Discounts and Allowances for all Levels	(1,017,462)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,923,669	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,065,852	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,065,852	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,116	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	548,633	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	76,551	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 626,300	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,160	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,160	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,605	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,605	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,638,586	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,686,259	31
32	Health Care	4,964,831	32
33	General Administration	3,831,282	33
	B. Capital Expense		
34	Ownership	1,400,894	34
	C. Ancillary Expense		
35	Special Cost Centers	538,832	35
36	Provider Participation Fee	164,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,586,798	40
41	Income before Income Taxes (line 30 minus line 40)**	51,788	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 51,788	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Halsted Terrace Nsg Ctr. Inc.

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Ending:

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,888	2,238	\$ 82,795	\$ 37.00	1
2	Assistant Director of Nursing	640	840	19,782	23.55	2
3	Registered Nurses	16,361	18,798	483,014	25.69	3
4	Licensed Practical Nurses	78,570	86,195	1,836,952	21.31	4
5	Nurse Aides & Orderlies	165,588	179,851	1,568,520	8.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,046	7,506	185,793	24.75	7
8	Rehab/Therapy Aides	10,718	12,827	147,944	11.53	8
9	Activity Director	1,912	2,080	25,897	12.45	9
10	Activity Assistants	16,763	19,114	163,993	8.58	10
11	Social Service Workers	8,171	10,077	143,096	14.20	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,080	28,245	13.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,890	35,613	274,496	7.71	15
16	Dishwashers					16
17	Maintenance Workers	8,003	8,603	104,668	12.17	17
18	Housekeepers	35,506	38,576	316,310	8.20	18
19	Laundry	10,377	10,948	84,175	7.69	19
20	Administrator	1,920	2,103	144,355	68.64	20
21	Assistant Administrator	635	683	11,686	17.11	21
22	Other Administrative	4,819	4,925	124,979	25.38	22
23	Office Manager					23
24	Clerical	22,318	25,264	559,357	22.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,960	2,080	33,571	16.14	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,292	3,516	60,422	17.18	33
34	TOTAL (lines 1 - 33)	431,241	473,917	\$ 6,400,050 *	\$ 13.50	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	364	\$ 11,640	01-03	35
36	Medical Director	Monthly	58,000	09-03	36
37	Medical Records Consultant	Monthly	344	10-03	37
38	Nurse Consultant	Fee	36,000	10-03	38
39	Pharmacist Consultant	Monthly	5,928	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	2	92	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,448	11-03	44
45	Social Service Consultant	63	3,992	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	429	\$ 118,444		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Bonzetta Williams	Administrator	0	\$ 56,644	Workers' Compensation Insurance	\$ 82,381		IDPH License Fee	\$ 2,346
David Hajdich	Administrator	0	84,690	Unemployment Compensation Insurance	90,402		Advertising: Employee Recruitment	81,490
Bernard Hollander	Administration	83.33	70,000	FICA Taxes	475,805		Health Care Worker Background Check	4,880
Mark Hollander	Executive	0	25,000	Employee Health Insurance	311,292		(Indicate # of checks performed <u>450</u>)	
Joanna Castro	VP of Operations	0	33,000	Employee Meals	27,596		Dues and Subscriptions	13,144
				Illinois Municipal Retirement Fund (IMRF)*			Licenses	1,018
See Supplemental Schedule			11,686	Head Tax	12,454		Allocate Carepath	179
TOTAL (agree to Schedule V, line 17, col. 1)				401K Expenses	4,050		Allocate ITTEX	1,076
(List each licensed administrator separately.)			\$ 281,020	Misc. Employee Benefits	1,156			
B. Administrative - Other				Pension Plan	30,870			
				Holiday Expenses	9,036			
Description			Amount				Less: Public Relations Expense	()
Management Fees - JLR Management			\$ 135,000				Non-allowable advertising	()
Management Fees - Shaymark			225,000				Yellow page advertising	()
Management Fees - Bernard Cohen (Adjusted Out on P. 5)			45,000					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,045,042		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 104,133
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 405,000					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
GiftRap Corp.	Computer Consulting		\$ 7,575					
Hlthcare Horizons(Adj Out P 5)	Administrative Consulting		4,800				In-State Travel	
Personnel Planners	Unemployment Consulting		3,252					
A.K. Care	Accounting		48,000					
FR&R	Accounting		20,351					
Achieve Accreditation	Joint Commission		3,989				Seminar Expense	6,830
A.K. Care	Bookkeeping		429,840				Allocate ITTEX	1,049
Care Path	Bookkeeping		20,361					
Power Software	Computer Consulting		11,685					
A.K. Care	Computer Consulting		268				Entertainment Expense	()
See Attached Schedule	Legal		70,540				(agree to Sch. V, line 24, col. 8)	
See Supplemental Schedule			6,165				TOTAL	\$ 7,879
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 626,826					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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STATE OF ILLINOIS

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - \$16,740; IL Assoc HC Fac \$1,500
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 74,660 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 164,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 27,596 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.